IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

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BUREAU OF FACILITY STANDARDS
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December 30, 2008

Merinda Halladay
Belmont Care Center Crestview
3625 Vaughn Street
Pocatello, ID 83204

RE: Belmont Care Center Crestview, Provider #13G050

Dear Ms. Halladay:

This is to advise you of the findings of the Medicaid/Licensure survey of Belmont Care Center Crestview, which was conducted on December 18, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **January 12, 2009,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by January 12, 2009. If a request for informal dispute resolution is received after January 12, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

Jim Trotter for
SHERRI CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

SC/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G050	A. BUILDING _____ B. WING _____	12/18/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT CARE CENTER CRESTVIEW	4024 MOUNTAIN LOOP POCATELLO, ID 83204

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W 000	INITIAL COMMENTS The following deficiencies were cited during your recertification survey. The survey was conducted by: Sherri Case, LSW,QMRP Common abbreviations/symbols used in this report are: BID - Twice daily HRC - Human Rights Committee IPP - Individual Program Plan LPN - Licensed Practical Nurse QMRP - Qualified Mental Retardation Professional	W 000	**Preparation and implementation of this plan of correction does not constitute admission or agreement by Belmont Management with the facts, findings, or other statements as alleged by the Bureau of Facility Standards concluded on December 18, 2008. Submission of this plan of correction is required by law and does not evidence the truth of some of the findings as stated by the survey agency. Belmont Management specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action.**	
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on review of the facility's policies and procedures and staff interview, it was determined the facility failed to adequately develop policies necessary to protect individuals from abuse, neglect and/or mistreatment by the Administrator for 8 of 8 individuals (Individuals #1 - #8) residing at the facility. This resulted in the potential for individuals to be unprotected from abuse, neglect and/or mistreatment. The findings include: 1. The facility's Abuse, Neglect, Mistreatment and Injuries of an Unknown Source policy, revised 1/30/04, did not include procedures to be followed if the Administrator was the person accused of abuse. Therefore, the policy did not identify who	W 149	**POC W149 483.420(d)(1)** **STAFF TREATMENT OF CLIENTS** If the Administrator is accused of Abuse, Neglect, or Mistreatment, the responsibility to investigate and perform the duties assigned to the Administrator will fall upon the Regional Director. This would include but is not limited to, immediate notification, immediate action to protect from further abuse, ability to suspend staff, and reporting to appropriate agencies. This will be stated in Belmont Managements Abuse, Neglect, Mistreatment and Injuries of Unknown Source policy. Training will be given to staff in the bi-annual Abuse training on the changes in this policy. Person Responsible: Regional Director and Administrator	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M. [illegible] TITLE: Administrator (X6) DATE: 1/9/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 149	Continued From page 1 was responsible to perform the duties assigned to the Administrator as the result of an abuse, neglect, or mistreatment allegation. Those duties included, but were not limited to, immediate notification, immediate action to protect from further abuse, ability to suspend staff, and reporting to appropriate agencies. When asked during an interview on 12/16/08 at 2:31 p.m., the Administrator stated the abuse policy did not include procedures to be followed if the Administrator was the person accused of abuse.	W 149	Monitor: Training will be completed on a bi-annual basis with all staff. During this training staff will be instructed on when the administrator is accused. The Regional Director will review quarterly all allegations.	2/18/09
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review, and staff interview it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the human rights committee for 1 of 4 individuals (Individual #2) whose Behavior Management/Support Plans were reviewed. This resulted in a lack of protection of an individual's rights through prior approvals on restrictive interventions. The findings include: 1. Individual #2's IPP, dated 2/28/08, documented a 49 year old male diagnosed with severe mental retardation. Individual #2's records included a Written	W 262	**POC W262 483.440(f)(3)(i) PROGRAM MONITORING & CHANGE** Belmont will ensure that the Human Rights Committee reviews, approves, and assists in monitoring individual programs or medications designed to assist in managing inappropriate behavior or any programs that involve risk to their protection and rights. We will review all previous restrictive interventions to ensure that they have been reviewed, and current approval has been given. All documentation will be collected and in order prior to the implementation of the restrictive medications or programming. Notes will be taken during all of the Human Rights Committee meetings to document the topics of the discussion and any approval given by the committee. The informed consent documents will be revised to include not only the acknowledgement of the Human Rights Committee but also the Behavior Specialist, Nurse, QMRP, and the Administrator.	

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W 262	Continued From page 2 Informed Consent, dated 6/1/08 for the use of Thorazine (an antipsychotic) to decrease his aggressive behaviors. A pharmacy review, dated 8/19/08, documented he was receiving Thorazine. However, his record did not contain evidence of HRC approval for the restrictive intervention. When asked during an interview on 12/18/08 from 8:45 - 9:40 a.m., the house manager stated there was no HRC approval. The facility failed to ensure the facility's HRC approval prior to the use of the restrictive intervention.	W 262	**Person Responsible: Behavior Specialist, LPN, QMRP, and Administrator** **Monitor: The informed consent will be revised to include the acknowledgement and signature of not only the Human Rights Committee but also the LPN, Behavior Specialist, QMRP, and Administrator prior to the implementation of the restrictive programming or medication. A checklist will be kept, providing documentation on when consents were obtained and will be reviewed during the monthly behavior meetings.**	2/18/09
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of the individuals' IPPs that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 3 of 3 individuals (Individuals #1, #2 and #3) whose medication reduction plans were reviewed. This resulted in individuals receiving behavior modifying drugs without plans that identified the drugs usage and how they may change in relation to progress or regression. The findings include: 1. Individual #1's 11/25/08 IPP stated he was a 60	W 312	**POC W312 483.450(e)(2) DRUG USAGE** **Belmont will ensure that medications used for the control of inappropriate behavior will be used as an integral part of the client's individual program plan that is directed specifically towards the reduction of and possible elimination of the behaviors for which the drugs are employed. The consumer will have a program in place for each of the medications that are being used for the control of inappropriate behavior. Belmont will review all medication reduction plans to ensure that correct information is present and that each of the required sections on the medication reduction plan is completed with specific information concerning the reduction plan. We will ensure that each required section on the reduction plan will be completed in a flow chart format and that each part is**	

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W 312	Continued From page 3 year old male whose diagnoses included mood disorder, depression and mild mental retardation. His physician order dated 11/20/08, stated he received Seroquel (an antipsychotic) 50 mg BID for mood disorder. He also received Remeron (an antidepressant) 30 mg daily before going to bed for depression and appetite. a. Individual #1's Psychotropic Medication Plan for Remeron, dated 2/11/04, included the following criteria to reduce the drug: - As per state regulations. - Individual #1 experienced severe, adverse side effects to the drug. - The treatment team, in coordination with the physician and HRC decided to increase other types of therapy while decreasing the drug. - The physician felt the drug could be decreased and still maintain a therapeutic level. The plan did not state how the use of the drug may change in relation to Individual #1's psychiatric signs and symptoms. When asked during an interview on 12/18/08 from 8:00 - 8:45 a.m., the Behavior Specialist and QMRP both stated criteria for reduction based upon Individual #1's psychiatric signs and symptoms was not included in the plan but should have been. b. Individual #1's Reduction Plan stated Remeron was prescribed for depression. His IPP did not include an objective related to depression. When asked, during an interview on 12/18/08 from 8:45 - 9:40 a.m., the QMRP stated data for Individual #1's symptoms for depression was kept, however, an objective had not been developed. c. Individual #1's Psychotropic Medication Plan	W 312	clearly defined with specific guidelines for reduction. The Medication Plan will define one of each of the following diagnosis, symptom, treatment plan, and objective criteria for each medication. In addition, individuals with multiple medications will have the order of reduction noted in their plans. These Reduction plans will be monitored through the data collected in the programs designed to manage the specific inappropriate behavior, monthly behavioral summaries, during monthly behavioral meetings, and quarterly with the psychiatrist. Person Responsible: Behavior Specialist, LPN, QMRP(s) and Administrator Monitor: These Reduction plans will be monitored through monthly behavioral summaries, during monthly behavioral meetings, and quarterly with the psychiatrist. In addition, the Behavior Specialist, QMRP(s), LPN, and Administrator will review monthly the status of the consumer and the criteria for reduction or change.	3/18/09

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W 312	Continued From page 4 for Seroquel, undated, included the following criteria to reduce the drug: - As per state regulations. - Individual #1 experienced severe, adverse side effects to the drug. - The treatment team, in coordination with the physician and HRC decided to increase other types of therapy while decreasing the drug. - The Seroquel is effective, but blood levels reflect a decrease would be effective. - The physician felt the drug could be decreased and still maintain a therapeutic level. The plan did not state how the use of the drug may change in relation to Individual #1's psychiatric signs and symptoms. When asked during an interview on 12/18/08 from 8:45 - 9:40 a.m., the Behavior Specialist and QMRP both stated criteria for reduction based upon Individual #1's psychiatric signs and symptoms was not included in the plan but should have been. The facility filed to ensure Individual #1's medication reduction plan included clear information related to the use of Remeron and Seroquel and how they would change in relation to progress or regression. 2. Individual #2's IPP, dated 2/28/08, documented a 49 year old male diagnosed with severe mental retardation and depression. a. Individual #2's records included a Psychotropic Medication Plan, undated, which stated he received Thorazine (an antipsychotic) to decrease his aggressive behaviors. However, his physician order, dated 11/20/08, stated he received the Thorazine to assist him with sleep. When asked	W 312		

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W 312	Continued From page 5 during an interview on 12/18/08 from 8:45 - 9:40 a.m., the Behavior Specialist stated the Thorazine was for sleep and the medication reduction plan was wrong. b. Individual #2's IPP did not include an objective related to sleep. When asked, during an interview on 12/17/08 from 8:45 - 9:45 a.m., the QMRP stated data was kept for Individual #2's sleep. However, an objective had not been developed. The facility failed to ensure Individual #2's medication reduction plan included accurate information. 3. Individual #3's IPP, dated 3/4/08, documented a 43 year old male diagnosed with profound mental retardation and depression. His physician order, dated 11/20/08, documented he received Paxil (an antidepressant) 20 mg for depression and impulsive behavior. a. Individual #3's Psychotropic Medication Plan, revised 3/26/08, included a diagnosis of profound mental retardation but did not include a diagnosis related to receiving the Paxil. During an interview on 12/18/08 from 8:45 - 9:40 a.m. when asked about a diagnosis for the Paxil, the QMRP stated the plan did not include a diagnosis for depression but should have. The facility failed to ensure Individual #3's medication reduction plan included accurate information.	W 312		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel.	W 440		

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W 440	Continued From page 6 This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure evacuation drills were conducted quarterly for each shift for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in the potential for the facility and staff not being able to determine individuals' responses nor identify problem areas. The findings include: 1. During a review of the facility's evacuation drills on 12/17/08, the following was noted: - There was no evacuation drill completed during the first quarter (January, February, March) for the day (6:30 a.m. - 2:30 p.m.). - There was no evacuation drill completed during the third quarter (July, August, September) for the night shift (10:30 p.m. - 6:30 a.m.). - There was no evacuation drill completed during the fourth quarter (October, November, December) for the swing shift swing shift (2:30 - 10:30 p.m.). When asked during an interview on 12/18/08 from 8:45 - 9:40 a.m., the Administrator stated the drills could not be found and she was unable to confirm they had been run. The facility failed to ensure evacuation drills were conducted at least quarterly on all shifts.	W 440	**POC W440 483.470(i)(1)** **EVACUATION DRILLS** Belmont will ensure that quarterly fire drills are completed and documented. The fire drills will be documented on the Care Tracker Kiosks. To ensure that Belmont is current on their fire drills, a drill will be run on each shift each month until they can be separated out back into the quarters. Person Responsible: Maintenance Supervisor, Home Supervisor, and Administrator Monitor: The Maintenance Supervisor and home supervisors will run the fire drills quarterly. They will complete the drills on the Kiosks. Reports will be pulled monthly and checked by the Administrator to ensure the drills were run.	3/18/09
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client.	W 474		

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W 474	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to ensure individuals received food consistent with their prescribed diets for 1 of 2 individuals (Individual #1) reviewed who were to receive a mechanical soft diet. This resulted in the potential for individuals to experience swallowing difficulties and possible aspiration. The findings include: 1. Individual #1's 11/25/08 IPP stated he was a 60 year old male whose diagnoses included mood disorder, depression and mild mental retardation. His physician order dated 11/20/08, showed he received a mechanical soft diet. During an observation on 12/16/08 at 12:05 p.m., he was noted to place a hot dog on a bun and eat it. The hot dog and bun were not noted to be modified to mechanical soft. When asked about Individual #1's diet, the LPN stated during an interview on 12/18/08 from 8:45 - 9:40 a.m., his food did not need to be mechanical soft if he was able to eat it without problems. However, Individual #1's Nutritional Assessment, dated 11/24/08, stated "[Individual #1] does not wear his dentures and needs his food presented mechanical soft. A specific prevention protocol will be placed in his book to help guide in food preparation and reduce the risk of choking." When asked on 12/18/08 at 12:00 p.m. if the dietary prevention protocol was developed the dietary aide stated it was not.	W 474	**POC W474 483.480(b)(2)(iii)** **MEAL SERVICE** Belmont will ensure that each individuals food be served in a form consistent with the developmental level of the consumer. The dietary manager will ensure the appropriate meal protocols are updated and available for staff to use. In addition the Dietary Manager, Dietician, and QMRP(s) will meet monthly to address the different meal protocols and ensure they are appropriate for each individuals needs. Person Responsible: Dietary Manager, Dietician, QMRP Monitor: The Dietician will ensure all recommended meal protocols are implemented. She will work with the Dietary Manager to ensure training is given to the staff on these protocols. During monthly meetings the QMRP, Dietary Manager, and Dietician will monitor the protocols in monthly dietary meetings.	3/18/09

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W 474	Continued From page 8 The facility failed to ensure Individual #1 received food consistent with his prescribed diet.	W 474		

Bureau of Facility Standards

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MM177	16.03.11.075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W149.	MM177	**POC MM177 16.03.11.075.09 Protection from Abuse and Restraint** Refer to Response W149 RECEIVED JAN 12 2009 FACILITY STANDARDS	2/18/09
MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194	**POC MM194 16.03.11.075.10(a) Approval of Human Rights Committee** Refer to W262	2/18/09
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W312.	MM197	**POC MM197 16.03.11.075.10(d) Written Plans** Refer to W312	2/18/09
MM337	16.03.11.110.04(c) Fire Drills A minimum of twelve (12) unannounced fire drills must be held annually, irregularly scheduled throughout all shifts. In addition, a least one (1) drill per shift must be held on a Sunday or holiday.	MM337	**POC MM337 16.03.11.110.04(c) Fire Drills** Refer to W440	2/18/09

Bureau of Facility Standards

M. Hallock — TITLE: Administrator — (X6) DATE: 1/9/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Facility Standards

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MM337	Continued From page 1 This Rule is not met as evidenced by: Refer to W440.	MM337		
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. The findings include: During an environmental review, conducted on 12/17/08 from 11:00 - 11:20 a.m., the following concerns were noted: - There was a 1 inch circular hole in the kitchen linoleum in front of the stove. - There was a build up of dust and grease on the light fixture above the stove. - The cover to the light fixture above the stove was cracked and a 1 inch section of plastic was missing. - The window screens were missing from the bay window in the living room and from Individual #6's bedroom.	MM380	**POC MM380 16.03.11.120.03(a) Building and Equipment** 1. The hole in the linoleum in front of the kitchen stove will be repaired. 2. The build up of grease on the light fixture was cleaned. 3. The cover to the light fixture above the stove will be repaired. 4. The screens in the living room and bedroom will be replaced. 5. The screen in individual #1's bedroom will be replaced. Person Responsible: Maintenance Supervisor, Residential Home Supervisor, and Administrator Monitor: Weekly facility inspections will be completed by the Residential Supervisor. Monthly facility inspections will be completed by the Maintenance Supervisor. Quarterly audits will be completed by the Administrator.	2/18/09

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G050	A. BUILDING _____ B. WING _____	12/18/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT CARE CENTER CRESTVIEW	4024 MOUNTAIN LOOP POCATELLO, ID 83204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM380	Continued From page 2 - The frame of the window screen in Individual #1's bedroom was bent preventing the screen from sealing around the window.	MM380		
MM678	16.03.11.250.08(c) Individual Resident's Needs Foods must be served in a form to meet individual resident's needs: This Rule is not met as evidenced by: Refer to W474.	MM678	**POC MM678 16.03.11.250.08(c) Individual Resident's Needs** Refer to Response W474	2/18/09